



PATIENT NAME: _____

BIRTH DATE: _____

DATE: _____

Name of Your Physician: _____ Office Telephone: _____

Address of Your Physician: _____

1. Have you ever been hospitalized, had any major operations or had any serious illnesses? Yes No

If yes, explain:

2. Have you been under a physician's care in the last 2 years? Yes No

If yes, explain:

3. With regard to cigarette smoking, how would you classify yourself? Current smoker Ex-smoker Never smoker

4. Do you currently use smokeless tobacco (e.g. snuff, plug)? Yes No
If yes, about how many times do you use smokeless tobacco per day? Less than 1 1-5 6-10 11-20 more than 20

5. Do you have (or have you ever been told you had) any of the following conditions? (circle all that apply)

- a. Congenital heart problems
- b. Infective endocarditis or other heart infection
- c. Artificial heart valves
- d. Heart Transplant
- e. Artificial joints or prostheses

6. Have you ever had an allergic reaction, or any other unusual reaction, to any of the following medications or substances?

If yes, what reaction(s) did you have to this substance? (circle all that apply)

- | | | | | | | | |
|---|-----|----|------|----------|---------------|----------|-------------------------------|
| a. Penicillin | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| b. Sulfa or other antibiotics | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| c. Aspirin | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| d. Codeine or morphine | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| e. Dental anesthetic (e.g. Novocain or lidocaine) | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| f. Latex | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| g. Airborne substances (e.g. pollen, perfume) | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| h. Other medications or substances (explain)_____ | | | | | | | |

7. Do you have (or have you ever been told you had) any of the following conditions?

- | | | | |
|--|-----|----|------------|
| a. High blood pressure (hypertension) | Yes | No | Don't Know |
| b. High cholesterol | Yes | No | Don't Know |
| c. Heart disease (e.g., angina, coronary artery disease, congestive heart failure) | Yes | No | Don't Know |
| d. Diabetes (sugar diabetes, blood sugar problems) | Yes | No | Don't Know |
| e. Cancer or tumors | Yes | No | Don't Know |
| f. Inflammatory diseases (e.g., arthritis, rheumatism, lupus, fibromyalgia) | Yes | No | Don't Know |
| g. Frequent Headaches | Yes | No | Don't Know |
| h. Asthma, emphysema, or other lung disease | Yes | No | Don't Know |
| i. Thyroid problems | Yes | No | Don't Know |
| j. Epilepsy or seizure disorders | Yes | No | Don't Know |
| k. Fainting or dizzy spells | Yes | No | Don't Know |
| l. Hepatitis or other liver disease | Yes | No | Don't Know |
| m. Tuberculosis (TB) | Yes | No | Don't Know |
| n. HIV+ or AIDS | Yes | No | Don't Know |
| o. Blood disorders (e.g., anemia, hemophilia) | Yes | No | Don't Know |
| p. Kidney problems | Yes | No | Don't Know |
| q. Stomach or intestinal problems | Yes | No | Don't Know |
| r. Phobias, severe anxieties, depression, or other psychological problems | Yes | No | Don't Know |
| s. Radiation, surgery, or chemotherapy to treat cancer | Yes | No | Don't Know |
| t. Bleed excessively after being cut or receiving dental care | Yes | No | Don't Know |
| u. Heart attack, stroke, or coronary bypass operation | Yes | No | Don't Know |
| v. Shortness of breath after climbing 1 flight of stairs | Yes | No | Don't Know |
| w. Pacemaker | Yes | No | |
| x. Pregnant or think you may be pregnant | Yes | No | |
| y. Breastfeeding | Yes | No | |
| z. Are there any other problems or issues about your health that you know of? | Yes | No | |

If yes, explain _____

8. Have you ever taken medications (such as bisphosphonates) that affect the bone or to prevent bone disease (e.g., Fosamax, Zometa, Actonel, Aredia)?

Yes No

9. Are you currently taking any medications or substances, including over-the-counter, prescription, vitamin, or herbal products, for any reason?

Please list below

Yes No

Medications or substances (with dosage)

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical and dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM: Signature: _____ Date: _____

If other than patient, indicate relationship to patient: _____